Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Huntington, WV - 581

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 117

2. Estimated Number of Veterans who are Chronically Homeless: 7

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 117 (estimated number of homeless veterans in service area) **x chronically homeless rate (6 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	240	0
Transitional Housing Beds	58	20
Permanent Housing Beds	26	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	HCHV staff continue to work with local homeless coalitions and Continuums of Care to address long-term, permanent housing concerns.
Help finding a job or getting employment	Continue to make referral to Volunteers of America DOL HVRP program. Huntington COC member initiative: Workforce West Virginia "OneStop" Center will provide job readiness training to 20 veterans.
Detoxification from substances	In an attempt to fill gap in detoxification services, the Huntington VAMC Mental Health Clinic/Substance Abuse Treatment Program will implement an outpatient detoxification program.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **21** **Non-VA staff Participants: 76.2%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.52	15.0%	3.47
Food	4.05	10.0%	3.80
Clothing	3.67	10.0%	3.61
Emergency (immediate) shelter	3.81	10.0%	3.33
Halfway house or transitional living facility	2.52	15.0%	3.07
Long-term, permanent housing	2.29	45.0%	2.49
Detoxification from substances	2.29	25.0%	3.41
Treatment for substance abuse	2.71	20.0%	3.55
Services for emotional or psychiatric problems	3.5	15.0%	3.46
Treatment for dual diagnosis	3.2	15.0%	3.30
Family counseling	2.76	.0%	2.99
Medical services	3.62	5.0%	3.78
Women's health care	3.37	.0%	3.23
Help with medication	3.38	5.0%	3.46
Drop-in center or day program	3.05	10.0%	2.98
AIDS/HIV testing/counseling	3.00	.0%	3.51
TB testing	3.52	.0%	3.71
TB treatment	3.38	.0%	3.57
Hepatitis C testing	3.05	5.0%	3.63
Dental care	2.48	15.0%	2.59
Eye care	2.57	5.0%	2.88
Glasses	2.52	.0%	2.88
VA disability/pension	2.76	.0%	3.40
Welfare payments	2.65	.0%	3.03
SSI/SSD process	2.60	5.0%	3.10
Guardianship (financial)	2.40	5.0%	2.85
Help managing money	2.40	.0%	2.87
Job training	2.45	10.0%	3.02
Help with finding a job or getting employment	2.86	30.0%	3.14
Help getting needed documents or identification	3.19	5.0%	3.28
Help with transportation	2.95	.0%	3.02
Education	2.67	5.0%	3.00
Child care	2.30	.0%	2.45
Legal assistance	2.20	5.0%	2.71
Discharge upgrade	2.43	.0%	3.00
Spiritual	3.05	.0%	3.36
Re-entry services for incarcerated veterans	2.10	10.0%	2.72
Elder Healthcare	2.40	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.19
Co-location of Services - Services from the VA and your agency provided in one location.	1.81
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.63
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.75
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.44
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.50
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.56
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.75
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.63
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.21
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.14
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.33

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.19
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.19

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Lexington, KY - 596

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 50

2. Estimated Number of Veterans who are Chronically Homeless: 21

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 50 (estimated number of homeless veterans in service area) **x chronically homeless rate (42 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	170	0
Transitional Housing Beds	140	50
Permanent Housing Beds	35	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue work with St. James Places in Lexington: completion of 30 additional single room occupancy apartments for homeless veterans with VA Grant and Per Diem funding.
Transitional living facility or halfway house	Continue work with Volunteers of American Program for homeless veterans to add 20 additional beds with current program at our Leestown Division.
Other	Need: increase staffing. Continue to work with management to increase homeless program FTEE from .4 to 1.0 for our homeless program.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **12 Non-VA staff Participants: 50.0%**
Homeless/Formerly Homeless: **66.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	4.40	.0%	3.47
Food	4.45	33.0%	3.80
Clothing	3.73	.0%	3.61
Emergency (immediate) shelter	4.45	33.0%	3.33
Halfway house or transitional living facility	4.27	33.0%	3.07
Long-term, permanent housing	3.00	33.0%	2.49
Detoxification from substances	4.70	.0%	3.41
Treatment for substance abuse	4.64	33.0%	3.55
Services for emotional or psychiatric problems	4.5	.0%	3.46
Treatment for dual diagnosis	3.5	.0%	3.30
Family counseling	3.30	.0%	2.99
Medical services	4.55	.0%	3.78
Women's health care	2.63	.0%	3.23
Help with medication	4.18	.0%	3.46
Drop-in center or day program	2.67	.0%	2.98
AIDS/HIV testing/counseling	3.33	.0%	3.51
TB testing	3.89	.0%	3.71
TB treatment	3.56	.0%	3.57
Hepatitis C testing	3.78	.0%	3.63
Dental care	3.91	33.0%	2.59
Eye care	2.55	.0%	2.88
Glasses	2.18	.0%	2.88
VA disability/pension	3.09	.0%	3.40
Welfare payments	2.36	.0%	3.03
SSI/SSD process	2.45	.0%	3.10
Guardianship (financial)	2.27	.0%	2.85
Help managing money	2.55	.0%	2.87
Job training	2.09	.0%	3.02
Help with finding a job or getting employment	2.36	.0%	3.14
Help getting needed documents or identification	2.91	.0%	3.28
Help with transportation	3.27	33.0%	3.02
Education	2.36	.0%	3.00
Child care	1.90	.0%	2.45
Legal assistance	2.20	33.0%	2.71
Discharge upgrade	2.56	.0%	3.00
Spiritual	3.82	.0%	3.36
Re-entry services for incarcerated veterans	2.67	33.0%	2.72
Elder Healthcare	2.89	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.00
Co-location of Services - Services from the VA and your agency provided in one location.	4.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	4.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	4.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	4.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	4.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	3.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	3.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	5.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	5.00

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Louisville, KY - 603

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 913

2. Estimated Number of Veterans who are Chronically Homeless: 183

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 913 (estimated number of homeless veterans in service area) **x chronically homeless rate (20 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	725	50
Transitional Housing Beds	564	50
Permanent Housing Beds	421	60

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue with informal agreements with HUD Shelter Plus Care and Louisville Metro Human Services which have assisted in providing opportunities for housing.
Services for emotional or psychiatric problems	Continue to identify homeless veterans in the community need services. Problems related to substance abuse and/or PTSD are to be identified and treatment provided.
Medical Services	Continue to refer homeless veterans to VA for medical care. Encourage veterans to participate in illness prevention activities such as smoking cessation, cholesterol screening, exercise, weight loss, and stress reduction.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **20** **Non-VA staff Participants: 70.0%**
Homeless/Formerly Homeless: **15.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.70	.0%	3.47
Food	4.30	10.0%	3.80
Clothing	3.60	5.0%	3.61
Emergency (immediate) shelter	3.60	5.0%	3.33
Halfway house or transitional living facility	2.84	.0%	3.07
Long-term, permanent housing	2.10	60.0%	2.49
Detoxification from substances	3.10	10.0%	3.41
Treatment for substance abuse	3.00	5.0%	3.55
Services for emotional or psychiatric problems	3.1	30.0%	3.46
Treatment for dual diagnosis	2.6	10.0%	3.30
Family counseling	2.65	5.0%	2.99
Medical services	3.00	25.0%	3.78
Women's health care	2.71	5.0%	3.23
Help with medication	2.65	5.0%	3.46
Drop-in center or day program	3.47	5.0%	2.98
AIDS/HIV testing/counseling	3.58	.0%	3.51
TB testing	4.16	.0%	3.71
TB treatment	4.11	.0%	3.57
Hepatitis C testing	3.58	5.0%	3.63
Dental care	2.20	15.0%	2.59
Eye care	2.35	.0%	2.88
Glasses	2.30	.0%	2.88
VA disability/pension	3.55	.0%	3.40
Welfare payments	3.10	.0%	3.03
SSI/SSD process	2.65	20.0%	3.10
Guardianship (financial)	2.55	10.0%	2.85
Help managing money	2.45	10.0%	2.87
Job training	3.25	.0%	3.02
Help with finding a job or getting employment	3.35	5.0%	3.14
Help getting needed documents or identification	2.95	5.0%	3.28
Help with transportation	2.95	15.0%	3.02
Education	3.10	.0%	3.00
Child care	2.55	5.0%	2.45
Legal assistance	2.90	5.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	3.60	5.0%	3.36
Re-entry services for incarcerated veterans	3.05	5.0%	2.72
Elder Healthcare	2.90	5.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.50
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.82
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.50
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.91
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.50
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.45
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.73
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.45

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.86
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.54

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Memphis, TN - 614

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1350

2. Estimated Number of Veterans who are Chronically Homeless: 243

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1350 (estimated number of homeless veterans in service area) **x chronically homeless rate (18 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	0
Transitional Housing Beds	126	20
Permanent Housing Beds	99	90

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Eye Care	Continues to be the top need. There is no free eye care service in the area. Try to develop an indigent program with University of Tennessee School of Optometry and other local eye care services.
Glasses	Even if veterans receive an eye exam, some may not be able to afford glasses. We will contact local opticians and optical goods stores to solicit donations for reading glasses.
Transitional living facility or halfway house	Transitional living facilities are needed for people with chronic health problems and dual diagnosis issues. Support facilities to apply for VA special needs grants.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **13** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.00	14.0%	3.47
Food	3.00	.0%	3.80
Clothing	3.22	.0%	3.61
Emergency (immediate) shelter	3.20	.0%	3.33
Halfway house or transitional living facility	3.00	29.0%	3.07
Long-term, permanent housing	2.44	14.0%	2.49
Detoxification from substances	2.67	.0%	3.41
Treatment for substance abuse	3.00	29.0%	3.55
Services for emotional or psychiatric problems	2.9	29.0%	3.46
Treatment for dual diagnosis	2.6	.0%	3.30
Family counseling	2.44	.0%	2.99
Medical services	3.11	13.0%	3.78
Women's health care	2.67	.0%	3.23
Help with medication	2.56	38.0%	3.46
Drop-in center or day program	2.44	.0%	2.98
AIDS/HIV testing/counseling	2.67	14.0%	3.51
TB testing	2.67	.0%	3.71
TB treatment	2.56	.0%	3.57
Hepatitis C testing	2.67	.0%	3.63
Dental care	2.22	29.0%	2.59
Eye care	2.33	14.0%	2.88
Glasses	2.44	14.0%	2.88
VA disability/pension	3.11	.0%	3.40
Welfare payments	2.44	.0%	3.03
SSI/SSD process	2.67	.0%	3.10
Guardianship (financial)	2.78	.0%	2.85
Help managing money	2.89	.0%	2.87
Job training	2.22	29.0%	3.02
Help with finding a job or getting employment	2.22	.0%	3.14
Help getting needed documents or identification	2.50	.0%	3.28
Help with transportation	2.56	.0%	3.02
Education	2.22	14.0%	3.00
Child care	2.25	.0%	2.45
Legal assistance	2.13	.0%	2.71
Discharge upgrade	2.13	.0%	3.00
Spiritual	2.44	14.0%	3.36
Re-entry services for incarcerated veterans	1.78	29.0%	2.72
Elder Healthcare	2.11	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.67
Co-location of Services - Services from the VA and your agency provided in one location.	1.29
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.29
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.50
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.57
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.29
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.29
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.29
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.43
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.25
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.43
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.86

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.08
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.83

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Mountain Home, TN - 621

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 650

2. Estimated Number of Veterans who are Chronically Homeless: 273

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 650 (estimated number of homeless veterans in service area) **x chronically homeless rate (42 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	220	50
Transitional Housing Beds	113	10
Permanent Housing Beds	28	80

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to expand HUD Shelter Plus Care. Two eight-bed facilities are targeted for conversion to long-term housing for homeless persons.
Dental care	Regional homeless coalition working to expand the very limited current dental resources for the homeless.
Job training	Address through regional coalition. Topic of discussion but no specific plan.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **18** **Non-VA staff Participants: 88.2%**
Homeless/Formerly Homeless: **11.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.73	.0%	3.47
Food	4.07	7.0%	3.80
Clothing	4.00	7.0%	3.61
Emergency (immediate) shelter	3.53	57.0%	3.33
Halfway house or transitional living facility	3.00	29.0%	3.07
Long-term, permanent housing	2.40	43.0%	2.49
Detoxification from substances	3.47	14.0%	3.41
Treatment for substance abuse	3.47	7.0%	3.55
Services for emotional or psychiatric problems	3.8	.0%	3.46
Treatment for dual diagnosis	3.5	.0%	3.30
Family counseling	3.00	7.0%	2.99
Medical services	4.07	7.0%	3.78
Women's health care	3.29	7.0%	3.23
Help with medication	3.93	.0%	3.46
Drop-in center or day program	2.54	14.0%	2.98
AIDS/HIV testing/counseling	3.29	7.0%	3.51
TB testing	3.93	.0%	3.71
TB treatment	3.79	.0%	3.57
Hepatitis C testing	3.71	.0%	3.63
Dental care	2.46	29.0%	2.59
Eye care	3.07	.0%	2.88
Glasses	3.07	.0%	2.88
VA disability/pension	3.79	.0%	3.40
Welfare payments	3.15	.0%	3.03
SSI/SSD process	3.50	.0%	3.10
Guardianship (financial)	3.17	14.0%	2.85
Help managing money	2.62	7.0%	2.87
Job training	3.00	14.0%	3.02
Help with finding a job or getting employment	3.00	14.0%	3.14
Help getting needed documents or identification	3.46	.0%	3.28
Help with transportation	3.00	14.0%	3.02
Education	3.38	.0%	3.00
Child care	2.55	.0%	2.45
Legal assistance	2.83	.0%	2.71
Discharge upgrade	3.40	.0%	3.00
Spiritual	4.08	.0%	3.36
Re-entry services for incarcerated veterans	2.80	.0%	2.72
Elder Healthcare	3.56	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.86
Co-location of Services - Services from the VA and your agency provided in one location.	1.93
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.86
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.82
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.58
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.55
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.55
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.91
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.82
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.70
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.60

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.29
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.21

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Nashville, TN - 626 (Nashville and Murfreesboro)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 500

2. Estimated Number of Veterans who are Chronically Homeless: 170

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 500 (estimated number of homeless veterans in service area) **x chronically homeless rate (34 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	546	380
Transitional Housing Beds	100	150
Permanent Housing Beds	60	250

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Continue to work closely with local agencies to promote community awareness of needs. Meet with local veterans services officers to increase awareness of need. Promote opportunities for new programs by working more directly with local political figures
Help finding a job or getting employment	Visit local employment security agencies to increase awareness of homeless veterans need and promote a closer relationship with placement counselors.
Help getting needed documents or identification	Meet with local veteran service organizations to increase awareness and enlist help through donations of money and time to assist with this need.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **14** **Non-VA staff Participants: 71.4%**
Homeless/Formerly Homeless: **7.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.29	.0%	3.47
Food	3.46	.0%	3.80
Clothing	3.43	.0%	3.61
Emergency (immediate) shelter	3.36	33.0%	3.33
Halfway house or transitional living facility	3.21	25.0%	3.07
Long-term, permanent housing	2.64	42.0%	2.49
Detoxification from substances	3.21	.0%	3.41
Treatment for substance abuse	3.21	42.0%	3.55
Services for emotional or psychiatric problems	3.3	33.0%	3.46
Treatment for dual diagnosis	2.8	8.0%	3.30
Family counseling	2.83	8.0%	2.99
Medical services	3.50	8.0%	3.78
Women's health care	2.91	.0%	3.23
Help with medication	3.00	8.0%	3.46
Drop-in center or day program	2.93	.0%	2.98
AIDS/HIV testing/counseling	3.29	.0%	3.51
TB testing	3.57	.0%	3.71
TB treatment	3.64	.0%	3.57
Hepatitis C testing	3.62	.0%	3.63
Dental care	2.50	8.0%	2.59
Eye care	2.71	8.0%	2.88
Glasses	2.43	8.0%	2.88
VA disability/pension	3.21	.0%	3.40
Welfare payments	2.69	.0%	3.03
SSI/SSD process	2.92	.0%	3.10
Guardianship (financial)	2.67	.0%	2.85
Help managing money	2.46	.0%	2.87
Job training	3.00	17.0%	3.02
Help with finding a job or getting employment	3.21	17.0%	3.14
Help getting needed documents or identification	3.23	8.0%	3.28
Help with transportation	2.54	8.0%	3.02
Education	2.77	.0%	3.00
Child care	2.31	.0%	2.45
Legal assistance	2.77	.0%	2.71
Discharge upgrade	3.15	.0%	3.00
Spiritual	3.36	.0%	3.36
Re-entry services for incarcerated veterans	2.57	8.0%	2.72
Elder Healthcare	2.93	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
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Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.20
Co-location of Services - Services from the VA and your agency provided in one location.	1.40
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.30
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.30
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.80
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.70
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.10
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.90
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.60
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.80
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.70

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.30
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.00